CHAPTER II

PROVIDER PARTICIPATION REQUIREMENTS

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PARTICIPATING PROVIDER

A participating provider must have a current, signed participation agreement with the Department of Medical Assistance Services (DMAS). Individuals must have a current and valid license from either the Virginia Department of Social Services (VDSS) or the Virginia Department of Health (VDH), as appropriate.

PROVIDER ENROLLMENT

Any provider of services must be enrolled in the Medicaid Program prior to billing for any services provided to Medicaid recipients. All providers must sign the appropriate Participation Agreement and return it to the Provider Enrollment and Certification Unit; an original signature of the individual provider is required. The authorized agent of the provider must sign an agreement for a group practice, hospital, or other agency or institution. The Virginia Medical Assistance Program must receive prior written ratification of the identity of any designated authorized representative and the fact that a principal-agent relationship exists.

Upon receipt of the above information, DMAS assigns a provider number to each approved provider. All claims and correspondence submitted to Medicaid must contain this number.

This manual contains instructions for billing and specific details concerning the Medicaid Program. Providers must comply with all sections of this manual to maintain continuous participation in the Medicaid Program.

REQUESTS FOR PARTICIPATION

To become a Medicaid provider of services, providers must obtain separate provider identification numbers for each physical or servicing location wanting to offer services to Virginia Medicaid recipients. The provider must request the participation agreement(s) by writing, telephoning, or faxing their requests to:

First Health Services
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-5105 or 1-888-829-5373 (in state toll-free), fax – 804-270-7027

Note: Licensure by the Virginia Department of Social Services does not constitute automatic enrollment as a Medicaid provider.

PARTICIPATION REQUIREMENTS

Providers approved for participation in the Medicaid Program must perform the following activities, as well as any other specified by DMAS:

- Immediately notify the Department of Medical Assistance Services, in writing, of any change in the information which the provider previously submitted to the Department;
- Assure freedom of choice to recipients in seeking medical care from any institution, pharmacy, or practitioner qualified to perform the service(s) required and participating in the Medicaid Program at the time the service was performed;
- Assure the recipient's freedom to reject medical care and treatment;
- Comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §§ 2000d through 2000d-4a), which requires that no person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the ground of race, color, or national origin.
- Provide services, good, and supplies to recipients in full compliance with the requirements of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), which states that no otherwise qualified individual with a disability shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Act requires reasonable accommodations for certain persons with disabilities.
- Provide services and supplies to recipients in the same quality and mode of delivery as provided to the general public;
- Charge Medicaid for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges to the general public;
- Not require, as a precondition for admission or continued stay, any period of private pay or a deposit from the patient or any other party;
- Accept Medicaid payment from the first day of eligibility if the provider was aware that an application for Medicaid eligibility was pending at the time of admission;
- Accept assignment of Medicare benefits for eligible Medicaid recipients;
- Use program-designated billing forms for submission of charges;

- Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided. Such records must be retained for a period of not less than five years from the date of service or as provided by applicable state laws, whichever period is longer. If an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved. (Refer to the section in this chapter regarding documentation.);

- Accept as payment in full the amount established by DMAS. 42 CFR § 447.15 provides that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency." A provider may not bill a recipient for a covered service regardless of whether the provider received payment from the State. A provider may not seek to collect from a Medicaid recipient, or any financially responsible relative or representative of that recipient, any amount that exceeds the established Medicaid allowance for the service rendered. The provider may not bill DMAS or recipients for broken or missed appointments.

  Example: If a third party payer reimburses $5 out of an $8 charge, and Medicaid's allowance is $5, then payment in full of the Medicaid allowance has been made. The provider may not attempt to collect the $3 difference from Medicaid, the recipient, a spouse, or a responsible relative;

- Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities;

- Disclose, as requested by Medicaid, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to recipients of medical assistance; and

- Hold confidential and use for authorized Medicaid purposes only all medical assistance information regarding recipients. A provider shall disclose information in his or her possession only when the information is used in conjunction with a claim for health benefits or the data is necessary for the functioning of DMAS. DMAS shall not disclose medical information to the public.

NOTICE OF PROVIDER RESPONSIBILITY

The provider is responsible for reading and adhering to the policies and regulations explained in this manual and for ensuring that all employees do likewise. The provider also certifies by his or her personal signature or the signature of an authorized agent on each invoice that all information provided to the Department of Medical Assistance Services (DMAS) is true, accurate, and complete. Satisfaction and payment of any claim will be from federal and State funds, and any provider who submits false claims, statements, or documents may be prosecuted under applicable federal and State laws.

PARTICIPATION CONDITIONS

All providers enrolled in the Virginia Medicaid Program must adhere to the conditions of participation outlined in their individual provider agreements. The following paragraphs outline special participation conditions for pre-admission screening providers.

Pre-admission screening shall be performed by local committees, and acute care and rehabilitation committees.

Local Committees

Local committees, to be organized by the local health director, are composed, at a minimum, of a physician, registered nurse, and social worker. The registered nurse and physician are required to be licensed or eligible to be licensed by the Commonwealth of Virginia to practice in the Commonwealth and must be employees of the local Health Department.

The social worker must be from the local department of social services. The committee, at the discretion of the local health director, may include representatives of other agencies providing community services to aged and disabled individuals. Experience in geriatrics or adult services is desired for all committee members. Screening committees may have additional members with other pertinent knowledge and expertise who do not meet these requirements.

In all instances, the assessment process, including the home visit, must be completed jointly by both the registered nurse and social worker. The physician must fully sign and date the authorization to receive services form (DMAS-96). No individual may sign or date for the physician. DMAS does not accept the use of electronic signatures or rubber stamps for any of the signatures that appear on the DMAS-96 form.

Acute Care Committees and Rehabilitation Committees

Acute Care committees and rehabilitation committees are composed of a social worker or discharge planner and physician in general acute-care hospitals, licensed private psychiatric hospitals, and free-standing rehabilitation hospitals. The social worker or discharge planner, if not a nurse, must collaborate with a registered nurse licensed or eligible to be licensed by the Commonwealth of Virginia to practice in the Commonwealth and knowledgeable about the individual's medical needs prior to completion of the screening process. Hospitals must seek prior approval from the DMAS if an exemption from social work involvement in the screening process is desired.

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT

Section 504 of the Rehabilitation Act, as amended (29 U.S.C. § 794) provides that no individual with a disability shall, solely by reason of the disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. As a condition of participation, each Medicaid provider is responsible for making provision for disabled individuals in his or her program activities.

As an agent of the federal government in the distribution of funds, DMAS is responsible for monitoring the compliance of individual providers. By signing or endorsing checks from DMAS, the provider indicates compliance with § 504 of the Rehabilitation Act.

In the event a discrimination complaint is lodged, DMAS is required to provide the Office of Civil Rights (OCR) with any evidence regarding compliance with these requirements.

RECORDS RETENTION

All pre-admission screening forms must be retained for a period of not less than five years from the date of the screening. This requirement is for all screening teams such as local health department, department of social services, and acute care hospitals.

DOCUMENTATION OF RECORDS

The provider agreement requires that the medical records fully disclose the extent of services provided to Medicaid recipients. The following elements are required documentation for medical records:

- The record must identify the patient on each page; and
- The responsible licensed participating provider must sign and date the entries. (The responsible licensed participating provider must countersign care rendered by personnel under the supervision of the provider, which is in accordance with Medicaid policy.)

TERMINATION OF PROVIDER PARTICIPATION

A participating provider may terminate participation in Medicaid at any time; however, written notification must be provided the DMAS Director and FH-PEU thirty (30) days prior to the effective date.

DMAS may terminate a provider from participating upon thirty (30) days written notification prior to the effective date. Such action precludes further payment by DMAS for services provided to customers subsequent to the date specified in the termination notice.

TERMINATION OF A PROVIDER CONTRACT UPON CONVICTION OF A FELONY

Section 32.1-325 D.2 of the Code of Virginia mandates that "Any such Medicaid agreement or contract shall terminate upon conviction of the provider of a felony." A provider convicted of a felony in Virginia or in any other of the 50 states must, within 30 days, notify DMAS of this conviction and relinquish the agreement. Reinstatement will be contingent upon provisions of state law.

RECONSIDERATION AND APPEALS OF ADVERSE ACTIONS

The following procedures will be available to all providers when DMAS takes adverse action which includes termination or suspension of the provider agreement and denial of payment for services rendered based on utilization review decisions.

The reconsideration and appeals process will consist of three phases: a written response and reconsideration to the findings, the informal conference, and the formal evidentiary hearing. The provider will have 30 days to submit information for written reconsideration and will have 30 days' notice to request the informal conference, formal evidentiary hearing, or both.

An appeal of adverse actions concerning provider reimbursement shall be heard in accordance with the Administrative Process Act (§ 2.2-4000 et seq.) and the *State Plan for Medical Assistanc*e provided for in § 32.1-325 of the Code of Virginia. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the Administrative Process Act.

Any legal representative of a provider must be duly licensed to practice in the Commonwealth of Virginia.

MEDICAID PROGRAM INFORMATION

Federal regulations governing program operations require Virginia Medicaid to supply program information to all providers. The current system for distributing this information is keyed to the provider number on the enrollment file, which means that each assigned provider receives program information. Providers enrolled at multiple locations or who are a member of a group using one central office may receive multiple copies of manuals, updates, and other publications sent by DMAS. Individual providers may request that publications not be mailed to them by completing a written request to the FIRST HEALTH - Provider Enrollment Unit at the address given under "Requests for Participation" earlier in this chapter.